

VIRGINIA DEPARTMENT OF SOCIAL SERVICES DIVISION OF LICENSING PROGRAMS				
CHILDREN'S RESIDENTIAL FACILITIES- RESIDENT RECORDS COMPLIANCE REVIEW				
Facility Name: _____		Date: _____		
Reviewed by: _____		# of Current Files: _____ # of Closed Files: _____		
	RESIDENT IDENTIFICATION ADMISSION/DISCHARGE DATE			
DISCHARGE				
§ 740.C	Resident's record shall contain a copy of the court order for a court-ordered discharge.			
§740.D	Discharged only to legal guardian or legally authorized representative			
§ 740.F	Information concerning current medications, needs for continuing therapeutic interventions, educational status, and other items important to the resident's continuing care shall be provided to the legal guardian or legally authorized representative, as appropriate (facility must document that info was provided).			
§ 740.G	Prior to planned discharge date;resident's record shall contain:			
§ 740.G.1	Documentation discharge planned and discussed with parent, legal guardian, child placing agency, and resident; and			
§ 740.G.2	A written discharge plan.			
§ 740.H	Discharge summary shall be placed in a resident's record and sent to the person/agency that made the placement no later than 30 days after discharge and shall include:			
§ 740.H.1.a	Services provided to the resident;			
§ 740.H.1.b.	Resident's progress towards meeting service plan objectives;			
§ 740.H.1.c	Resident's continuing needs and recommendations, if any, for further services and care;			
§ 740.H.1.d	Reasons for discharge and names of persons to whom resident was discharged;			
§ 740.H.1.e	Dates of admission and discharge; and			
§ 740.H.1.f	Date the discharge summary was prepared and the signature of the person preparing it.			

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FACE SHEET				
§ 700.E	The following information shall be added to the face sheet at the time of discharge:			
§ 700.E.1	Date of discharge;			
§ 700.E.2	Reason for discharge;			
§ 700.E.3	Name and addresses of persons to whom the resident was discharged; and			
§ 700.E.4	Forwarding address of the resident, if known.			
§ 700.A	At the time of admission; resident's record shall contain a completed face sheet containing:			
	Resident's full name;			
	Last known residence;			
	Birth date;			
	Birthplace;			
	Gender;			
	Race;			
	Social security number or other unique identifier;			
	Religious preference;			
	Admission date;			
	Names of resident's legal guardians, placing agency, and emergency contacts and parents, if appropriate;			
	Addresses of resident's legal guardians, placing agency and emergency contacts and parents, if appropriate; and			
	Phone numbers of resident's legal guardians, placing agency, and emergency contacts and parents, if appropriate.			
§ 700. B	Information shall be updated when changes occur.			
§ 700.C	The face sheet for pregnant teens shall include:			
	Expected date of delivery; and			
	Name of hospital to provide delivery services.			

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§ 700.D	The face sheet for residents who are transferred to facilities operated by the same sponsor shall:			
	Indicate the address of each location and			
	Dates of placement/transfer at each location			
ADMISSIONS				
§ 670	Emergency and self-admissions:			
§ 670.1	Documentation of prompt efforts made to obtain a court order or a written placement agreement signed by legal guardian.			
§ 670.2	Resident 's record contains a court order,a written request for care or documentation of an oral request for care. <u>AND</u> Justification of why resident admitted on emergency basis			
§670.3	Documentation in written assessment information that the individual meets facility's criteria for admission			
§ 680	Application for Admission:			
§ 680.B	Fully completed admission application prior to acceptance for care and includes information necessary to determine the:			
§ 680.B.1	Educational needs of the resident			
§ 680.B.2	Mental health, emotional and psychological needs of the resident;			
§ 680.B.3	Physical health and immunization needs of the resident;			
§ 680.B.4	Protection needs of the resident;			
§ 680.B.5	Suitability of the resident's admission;			
§ 680.B.6	Behavior Support needs of the prospective resident			
§ 680.B.7	Information necessary to develop a service plan and a behavior support plan.			
§ 680.C	Resident's record shall contain a completed application for admission at the time of a routine admission or within 30 days after an emergency admission.			

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§ 690	Written placement agreement:			
§ 690.A.1	Authorizes the resident's placement;			
§ 690.A.2	Addresses acquisition of and consent for any medical treatment needed by the resident;			
§ 690.A.3	Addresses the rights and responsibilities of each party involved;			
§ 690.A.4	Addresses financial responsibility for the placement;			
§ 690.A.5	Addresses visitation with the resident.			
§ 690.A.6	Addresses education plan for resident and responsibilities of all parties.			
§ 690.B	Prior to routine admission, resident's record contains the completed placement agreement, signed by a facility representative & the legal guardian or placing agency except as permitted for temporary emergency shelters pursuant to the Code of Virginia.			
§ 690.C	Resident's record contains a copy of the court order for court-ordered placements.			
§ 640.A	Separate written or automated case record for each resident			
§ 640.B	Case record up to date and uniform			

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	ISP's, QUARTERLY REVIEWS, & BSP'S			
§ 710	Initial objectives and Strategies: Within 3 days following admission, individualized measurable objectives and strategies for the first 30 days shall be: developed, distributed to affected staff, distributed to the resident and, placed in the resident's record.			
§ 720.A	Individualized service plan (ISP) developed and placed in the resident's record within 30 days following admission & implemented immediately thereafter.			
§ 720.B	ISP's shall describe in measurable terms:			
§ 720.B.1	Strengths and needs of the resident;			
§ 720.B.2	Resident's current level of functioning;			
§ 720.B.3	Goals, objectives, and strategies established for the resident;			
§ 720.B.4	Projected family involvement;			
§ 720.B.5	Projected date for accomplishing each objective; and			
§ 720.B.6	Status of projected discharge plan & estimated length of stay.			
§ 720.C	The initial plan shall be reviewed: within 60 days of the initial plan date & within each 90-day period thereafter AND the initial plan shall be revised as necessary:			
§ 720.E	Documented quarterly review (QPR) of each resident's progress: within 60 days following the initial plan date & within each 90-day period thereafter AND the review shall report:			
§ 720.E.1	Resident's progress toward meeting the plan's objectives;			
§ 720.E.2	Family's involvement;			
§ 720.E.3	Continuing needs of the resident;			
§ 720.E.4	Resident's progress toward discharge;			
§ 720.E.5	Status of discharge planning.			
§ 720.F	Each ISP and QPR shall include: the <u>date it was developed</u> AND <u>signature of the person</u> who developed it.			

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§ 720.H	There shall be documentation of the involvement of the following parties in developing and updating the ISP and in developing the QPR:			
§ 720.H.1	Resident;			
§ 720.H.2	Resident's legal guardian AND family (if appropriate)			
§ 720.H.3	Placing agency; and			
§ 720.H.4	Facility staff.			
§ 720.I	Documentation of distribution of the initial service plan, each update, and all quarterly progress reports to the <u>resident, resident's family, legal guardian or legally authorized representative, placing agency and appropriate facility staff.</u>			
§860.A	Behavior support plan (BSP) that allows the resident to self-manage his own behavior shall be developed and implemented within 30 days of admission and include:			
§860.A.1	Identification of positive AND problem behavior			
§860.A.2	Identification of triggers for behaviors			
§860.A.3	Identification of successful intervention strategies for problem behavior			
§860.A.4	Techniques for managing anger AND anxiety			
§860.A.5	Identification of interventions that may escalate inappropriate behaviors			
§860.B	Individual BSP shall be developed in consultation with: 1. Resident 2. Legal Guardian 3. Resident's Parents 4. Program Director 5. Placing Agency Staff 6. Other Appropriate Individuals			

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CASE MANAGEMENT SERVICES				
§ 760.B	Provision of case management services documented in the resident's record.			
SERIOUS INCIDENT REPORTS, TIMEOUT, AND PHYSICAL RESTRAINT				
§ 1020.A	Any serious incident, accident or injury to the resident; any overnight absence from the facility without permission; any runaway; and any other unexplained absences shall be reported within 24 hours: (i) to the placing agency, (ii) to either the parent or legal guardian, or both as appropriate, (iii) recorded in the resident's record.			
§ 1020.B	Serious incident reports shall include:			
§ 1020.B.1	Date and time incident occurred;			
§ 1020.B.2	Brief description of the incident;			
§ 1020.B.3	Action taken as a result of the incident;			
§ 1020.B.4	Name of the person who completed report;			
§ 1020.B.5	Name of person who made report to the placing agency and to either the parent or legal guardian; and			
§ 1020.B.6	Name of person to whom report was made.			
§ 1030.C	Any case of suspected child abuse or neglect occurring at the facility, on a facility-sponsored event or excursion, or involving facility staff shall be <u>reported immediately</u> (i) to the <u>regulatory authority AND placing agency</u> and (ii) to either the resident's parent or legal guardian, or both, as <u>appropriate</u> .			
§ 1030.B	Any case of suspected child abuse or neglect shall be <u>reported to the local Child Protective Services</u> as required by the <i>Code of Virginia</i> .			
§ 1030.D	When a case of suspected child abuse or neglect is reported to CPS, the resident's record shall include:			
§ 1030.D.1	Date and time suspected abuse or neglect occurred;			
§ 1030.D.2	Description of the suspected abuse or neglect;			
§ 1030.D.3	Action taken as a result of the suspected abuse or neglect; and			

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§ 1030.D.4	Name of person to whom report was made at the local child protective services unit.			
§ 870.E	Use of timeout and staff checks shall be documented when used for managing resident behavior.			
§ 900.I	Each application of physical restraint shall be documented in the resident's record including:			
§ 900.I.1	Date;			
§ 900.I.2	Time;			
§ 900.I.3	Staff involved;			
§ 900.I.4	Justification for restraint;			
§ 900.I.5	Unsuccessful less intrusive restrictive interventions attempted.			
§ 900.I.6	Duration;			
§ 900.I.7	Description of Method(s) of physical restraint techniques used;			
§ 900.I.8	Signature of person completing report AND date			
§ 900.I.9	Reviewers signature AND date			
TRANSFER OF RESIDENTS BETWEEN RESIDENTIAL FACILITIES LOCATED IN VIRGINIA AND OPERATED BY THE SAME SPONSOR				
§ 730	At the time of transfer, the receiving provider shall document:			
§ 730.1	Preparation through sharing information with the resident, the family, and the placing agency about the: facility, staff, population served, activities, and admission criteria;			
§ 730.2	Notification to the family, if appropriate; the resident, placing agency and legal guardian;			
§ 730.3	Receipt from sending facility of a written summary of resident's progress while at the facility, justification for the transfer, and the resident's current strengths and needs; and			
§ 730.4	Receipt of the resident's record.			
§ 730.B	The sending facility shall retain a copy of the face sheet and a written summary of the child's progress while at the facility and shall document the date of transfer and the name of the facility to which the resident has been transferred.			

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INTERSTATE PLACEMENT OF CHILDREN (ICPC)				
§ 650.A	Documentation of prior approval by Interstate Compact Administrator for child accepted from outside Virginia.			
§ 650.B	Documentation that provider has sent to Virginia ICPC Administrator copies of all serious incident reports regarding children placed through interstate compact.			
§ 650.C	No later than 5 days after a resident has been transferred to another facility operated by the same sponsor, the resident's record shall contain documentation that the Virginia ICPC administrator was notified in writing of the resident's transfer.			
§ 650.D	No later than 10 days after discharge the resident's record shall contain documentation that the Interstate Compact Administrator was notified of the discharge.			
EDUCATION				
§ 920.A	Documentation of educational enrollment shall be kept in the resident's record.			
§ 920 D	Documentation of facility's contact with division superintendent of resident's home school locality regarding residential placement.			
HEALTH CARE PROCEDURES				
§ 790.B	The following written information concerning each resident shall be readily accessible to staff who may need to respond to a medical or dental emergency:			
§ 790.B.1	Name, address, and telephone number of the physician and dentist to be notified;			
§ 790.B.2	Name, address, and telephone number of a relative or other persons to be notified;			
§ 790.B.3	Medical insurance company name and policy number or Medicaid number;			
§ 790.B.4	Information concerning:			
§ 790.B.4.a	Use of medication;			
§ 790.B.4.b	All allergies, INCLUDING medication allergies;			

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§ 790.B.4.c	Substance abuse AND use; and			
§ 790.B.4.d	Significant past AND present medical problems;			
§ 790.B.5	Written permission for emergency medical care, dental care, and obtaining immunizations or a procedure and contacts for obtaining consent.			
PHYSICAL EXAMS				
§ 800.A	Each child accepted for care shall have a physical examination by or under direction of a licensed physician no earlier than 90 days prior to admission to the facility or no later than 7 days following admission except:			
§ 800.A.(i)	When a child transfers from another residential facility licensed or certified by a state agency to another then the requirement is to have a physical within the preceding 12 months;			
§ 800.A.(ii)	If a report of physical exam is not available for an emergency admission then the requirement is to have a physical exam conducted within 30 days following an emergency admission.			
§ 800.A.(iii)	No physical examination is required for temporary care and secure detention facilities.			
§ 800.B	TB screening assessment within 7 days of placement (assessment form contains elements of VDH published form)			
§ 800.C	TB screening assessment Annually (assessment form contains elements of VDH published form)			
§ 800.D	Documentation is required for:			
§ 800.D.(i)	The initial physical exam;			
§ 800.D.(ii)	An annual physical; and			
§ 800.D.(iii)	Documentation of provision of follow-up care recommended by the physician or as indicated by the needs of the resident.			
§ 800.E	Each physical exam report shall include:			
§ 800.E.1	Information necessary to determine the health and immunization needs of the resident including:			
§ 800.E.1.a	Immunizations administered AT TIME OF EXAM;			
§ 800.E.1.b	Vision exam;			

§ 800.E.1.c	Hearing exam;			
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§ 800.E.1.d	General physical condition, including documentation of apparent freedom from communicable disease including TB;			
§ 800.E.1.e	Allergies, chronic conditions, and handicaps, if any;			
§ 800.E.1.f	Nutritional requirements, including special diets, if any;			
§ 800.E.1.g	Restrictions on physical activities, if any; and			
§ 800.E.1.h	Recommendations for further treatment, immunizations, and other examinations indicated;			
§ 800.E.2	Date of physical examination; and			
§ 800.E.3	Signature of licensed physician, physician's designee, or an official of a local health department.			
ANNUAL EXAMINATIONS BY LICENSED DENTIST				
§ 800.G	Annual examination by a licensed dentist and documentation of follow-up dental care as recommended by the dentist or as indicated by the needs of the resident .			
HEALTH & DENTAL COMPLAINTS				
§ 800.H	Notations of health and dental complaints and injuries showing symptoms and treatment given.			
PSYCHIATRIC & MENTAL HEALTH TREATMENT				
§ 800.I	If applicable, current health record shall include treatment summaries of ongoing psychiatric or other mental health treatment and reports or documentation of the facility's efforts to obtain the information.			
§ 810.F	Medication Administration Record includes: 1. date prescribed, 2. drug name, 3. administration schedule, 4. strength, 5. route, 6. identity of individual who administered medication and, 7. dates discontinued or changed			
§ 810.G	Medication error or adverse drug reaction-actions taken by staff shall be documented			

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§ 810.H	Documentation of medication refusals <u>including</u> actions taken by staff.			
INDEPENDENT LIVING PROGRAMS				
§1060.B	Within 14 days of placement-assessment of resident's life skills * assessment includes strengths & needs of resident *assessment tool is approved by regulatory authority			
§1060.C	The ISP shall include goals, objectives and strategies to address each of the following areas, as applicable: 1. money management and consumer awareness 2. food management 3. personal appearance 4. social skills 5. health/sexuality 6. housekeeping 7. transportation 8. educational planning/career planning 9. job-seeking skills 10. job maintenance skills			
	11. emergency and safety skills 12. knowledge of community resources 13. interpersonal skills/social relationships 14. legal skills 15. leisure activities 16. housing			

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MOTHER/BABY PROGRAMS				
§1070.C	At time of admission, a placement agreement signed by legal guardian for each adolescent mother <u>AND</u> a separate placement agreement signed for each child			
§1070.D	Application for admission for the adolescent's child must include: 1. placement history of the child 2. developmental milestones of the child 3. nutritional needs of the child			
§1070.E	Face sheet for the adolescent's child shall also include: 1. Type of delivery; 2. Weight & length at birth; 3. Any medications or allergies; AND 4. Name and address, if known, of the biological father			
§1070.F	Within 30 days of the admission of the adolescent's child, combined service plan following requirements of §720 must be written for the adolescent mother and her child			
§1070.G	Combined documented review of the adolescent mother's and her child's progress following the requirements of the quarterly report 60 days following the first combined service plan and within each 90 day period thereafter			
§1070.H	Developmental milestones of the adolescent's child must be documented in each quarterly progress report			
§1070.I	The record of each child 18 months or younger shall include the child's feeding schedule AND directions for feeding.			
§1070.P	A daily log must be kept for each child of the adolescent mother showing what activities the child actually participated in during the day. Log must show that children have the opportunity to participate in sensory, language, manipulative, building, large muscle, and learning activities.			

CAMPSITE PROGRAMS OR ADVENTURE ACTIVITIES				
§1080.I	Resident's record contains documentation that trip coordinator classified his swimming ability as either a swimmer or nonswimmer (NOTE: check the trip folder to ensure documentation is ther also).			